

City Of
Locust Grove
Georgia



EMPLOYEE BENEFITS HANDBOOK

Plan Year December 1, 2017 thru November 30, 2018



**Go online and enroll at www.eelect.com
Enrollment ID = **94993**
Employee ID = **SSN****

This handbook includes information on the following:

**Medical Benefits | Health Reimbursement Arrangement | Dental Benefits
Life Insurance | Disability Insurance | Employee Assistance Program
COBRA Notification | Contact Information**

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This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available in the Human Resources department. In the event that some information changes, you will receive notice about the changes prior to the annual Open Enrollment. If you are a new employee, this information will help you to understand the benefit options available to you. If you're already covered by any of the benefit plans, you may refer to this booklet throughout the year as you use your benefits. This booklet also provides information regarding your COBRA rights and responsibilities.

ELIGIBILITY

Newly hired full-time employees are eligible for benefits on the first day of the month following 30 days of service. Spouses and dependent children of the employee are also eligible to participate in our benefit plans. Dependent children include natural children, legally adopted children, stepchildren, and children for whom the employee has been appointed guardian. Federal law requires all health plans to report social security numbers for employees and covered dependents. Please make sure to have all necessary names, birthdates and social security numbers available for your enrollment.

CHANGES

Pre-Tax Deduction of Premiums (Section 125 Plan) - Health insurance premiums are deducted (if you have elected deductions) from your pay on a pre-tax basis (exempt from FICA, Federal and State tax) which in turn provides significant cost savings. This will continue and does not require any action on your part unless you desire to make changes. You will be able to make changes on any of your elections during the open enrollment period. Your selections cannot be changed until next year unless the revocation and new election are due to and consistent with a valid status change (e.g., marriage, divorce, death of a spouse or child, birth or adoption of a child or change of employment of your spouse as detailed in the Section 125 Regulations). **If you have a status change during the year you must notify Human Resources within 30 days. Any request to make changes after 30 days will not be allowed until the next annual open enrollment.** Please contact the City at (770) 957-5043 if you have any questions regarding the open enrollment period or changes.

MESSAGE FROM MAYOR PRICE



To: All Full Time Employees
From: Robert Price
Subject: Employee Benefits

The City of Locust Grove appreciates very much the hard work and dedication of all our employees and we recognize that a quality, comprehensive benefits package is a critical component in retaining skilled and seasoned employees as well as recruiting new talent when needed.

This handbook is provided to you as a quick reference tool for information regarding many features of the various benefit plans offered to our employees. You will find answers to many of your benefit questions in this handbook as well as contact information for a variety of resources.

On behalf of all council members, we thank you for all of your hard work!

Robert Price
Mayor
City of Locust Grove

LOCUST GROVE CITY COUNCIL

Vernon Ashe
Councilman
2016 - 2020

Keith Boone
Councilman
2014 - 2018

Willie Taylor
Councilman
2015 - 2018

Otis Hammock
Councilman
2016 - 2020

Carlos Greer
Councilman
2016 - 2020

Sammy Brown
Councilman
2014 - 2018

ONLINE ENROLLMENT INSTRUCTIONS

You can now go online and enroll in your benefits while at home, with your spouse, on your work computer or simply on your own time.

If you know what benefits you want to elect for the new plan year and don't have any questions then you have the option to confirm your new elections online without having to take time out of your busy schedule for the open enrollment meetings.

How do I enroll online?

Simply follow the below instructions to confirm your new benefit elections...

Go to: www.eElect.com



The City of Locust Grove Enrollment ID is **94993** (enter this in the box and click continue)

You will then see "City of Locust Grove Employee Benefits Enrollment System" at the top of the page. Enter your full **social security number** (without dashes) in the "Log In" box shown below:

Log In
Please enter your nine digit Employee Identification Number:

Continue >>

Click **continue** and then follow the prompts through the entire enrollment.

Once you see the below message you may print the confirmation or exit the enrollment. At this point you have completed your enrollment.

CONFIRMATION

CONGRATULATIONS, you have now successfully completed your enrollment

You may either...

- Click below on "**Print Confirmation**" to print your benefit election(s) or
- Click below on "**Exit Enrollment**" to exit the enrollment session

SIDE by SIDE MEDICAL COMPARISON

The City of Locust Grove offers two (2) Coventry Health Care of Georgia health plan options, a \$3,500 deductible plan and a \$5,000 deductible plan. You will automatically be enrolled in a Health Reimbursement Arrangement (HRA) that the City has established to help with the annual medical deductible. The HRA will reimburse you the last \$1,000 (includes specialist, ER, urgent care and Rx) of the annual medical deductible for the \$3,500 Choice Plan or the last \$2,500 (inpatient/outpatient services) of the annual medical deductible for the \$5,000 Premier Plus Plan. Please see page 9 for a detailed explanation of the HRA.

IN-NETWORK	\$3,500 Choice Plan	\$5,000 Premier Plus Plan
Individual Annual Deductible	\$3,500	\$5,000
Health Reimbursement Arrangement (HRA)*	- \$1,000	- \$2,500
Net Annual Deductible	\$2,500	\$2,500
Individual Out-of-Pocket Maximum (excludes deductible/copays)	N/A	N/A
Member Co-Insurance	Member Pays 0% Plan Pays 100%	Member Pays 0% Plan Pays 100%
Primary Care Physician Copay	\$35	\$30
Specialist Physician Copay	Deductible + \$50	\$60
Preventive Health Services*	No Cost to the Member	
Urgent Care Copay	Deductible + \$75	\$75
Emergency Room Copay (waived if admitted)	Deductible + \$150	\$200
Inpatient Surgery	Deductible	Deductible
Outpatient Surgery	Deductible	\$100 Copay + Deductible

*Preventive Health Services are defined in the Affordable Care Act and do not have any member cost sharing responsibility for In-Network services.

OUT-OF-NETWORK	\$3,500 Choice Plan	\$5,000 Premier Plus Plan
Individual Annual Deductible	\$7,000	\$5,000
Health Reimbursement Arrangement (HRA)*	- \$1,000	- \$2,500
Net Annual Deductible	\$6,000	\$2,500
Individual Out-of-Pocket Maximum (excludes deductible)	\$10,000	\$3,000
Member Co-Insurance	Member pays 40% Plan pays 60%	Member pays 30% Plan pays 70%
PRESCRIPTION DRUG CO-PAYMENTS	\$3,500 Choice Plan	\$5,000 Premier Plus Plan
Your copayment for up to a 31 day supply of Prescription Drugs <i>other than</i> Self-Administered Injectable Drugs:		
Deductible - Tier's 2, 3, and 4 only	\$3,500	No Deductible
Prescription Drug - Tier 1A - Deductible requirements do not apply	\$3	\$3
Prescription Drug - Tier 1 - Deductible requirements do not apply	\$15	\$15
Prescription Drug - Tier 2	\$35	\$35
Prescription Drug - Tier 3	\$65	\$65
Self-Administered Injectable or Specialty Pharmacy Tier 4 Prescription Drugs	\$100	10%

* The HRA amount is combined between in and out-of-network

EMPLOYEE DEDUCTIONS

Bi-Weekly (26 / year)

MEMBERS COVERED	\$3,500 Choice Plan	\$5,000 Premier Plus Plan
Employee Only	\$ 22.84	\$ 62.89
Employee + Spouse	\$188.73	\$272.85
Employee + Child(ren)	\$155.30	\$233.41
Employee + Family	\$235.80	\$357.98

TOBACCO SURCHARGE: A \$25 per month surcharge will be applied to the health insurance premium for any employee and/or covered spouse who have used tobacco products within the past 90 days. If you complete the free smoking cessation program offered through our Employee Assistance Program (EAP) the charge will be reduced to \$15 per month. More information about the EAP and the smoking cessation program can be found on page 17. You will be required to answer the tobacco user question during the electronic enrollment.

\$3,500 CHOICE PLAN BENEFIT SUMMARY



BENEFITS	MEMBER PAYS	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	Individual: \$3,500 Family: \$7,000	Individual: \$7,000 Family: \$14,000
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: NA Family: NA	Individual: \$10,000 Family: \$20,000
PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in a physician's office.		
Office Visits	\$35 Copay	Deductible + 40%
Allergy Testing, Treatment and Injections	\$35 Copay	Deductible + 40%
Chemotherapy and Radiation	\$35 Copay	Deductible + 40%
Family Planning	\$35 Copay	Deductible + 40%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	\$35 Copay	Deductible + 40%
Radiology - <i>When test is performed in physician's office</i>	\$35 Copay	Deductible + 40%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
SPECIALIST PHYSICIAN SERVICES - When performed and billed in a physician's office.		
Office Visits	Deductible, then \$50	Deductible + 40%
Allergy Testing, Treatment and Injections	Deductible, then \$50	Deductible + 40%
Chemotherapy and Radiation	Deductible, then \$50	Deductible + 40%
Family Planning	Deductible, then \$50	Deductible + 40%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	Deductible, then \$50	Deductible + 40%
Radiology - <i>When test is performed in physician's office</i>	Deductible, then \$50	Deductible + 40%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
PREVENTIVE HEALTH SERVICES		
Annual Adult Physical	No cost to the member	Deductible + 40%
Annual Well-Woman exam (including annual Pap smear)	No cost to the member	Deductible + 40%
Immunizations and Vaccines	No cost to the member	Deductible + 40%
Well-Child Care / Newborn Care	No cost to the member	40% Coinsurance
Mammogram	No cost to the member	Deductible + 40%
<i>This is not intended to be an all-inclusive list. Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network services.</i>		
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services	Deductible	Deductible + 40%
Inpatient Rehabilitation Facility	Deductible	Deductible + 40%
Physician Services	Deductible	Deductible + 40%
MATERNITY SERVICES		
Physician Services - <i>one time copay per pregnancy (In-Network Only)</i>	One time \$250 copay	Deductible + 40%
Inpatient Maternity Care	Deductible	Deductible + 40%
<i>Radiology (ultrasound) for Maternity, when done outside physician office may result in additional member responsibility.</i>		
OUTPATIENT THERAPY SERVICES		
Cardiac Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	Deductible, then \$50	Deductible + 40%
Pulmonary Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	Deductible, then \$50	Deductible + 40%
Physical and Occupational Therapies - <i>Limited to 20 visits annually (combined)</i>	Deductible, then \$50	Deductible + 40%
Speech Therapy - <i>Limited to 20 visits annually</i>	Deductible, then \$50	Deductible + 40%
CONVENIENCE CARE SERVICES		
Convenience Care Visit	\$35 copay	\$35 copay
URGENT AND EMERGENT CARE		
Urgent Care in an Urgent Care Facility	Deductible, then \$75 Copay	Deductible, then \$75 Copay
Emergency Services - <i>Copay is waived if admitted</i>	Deductible, then \$150 Copay	Deductible, then \$150 Copay
Ambulance	Deductible, then \$150 Copay	Deductible, then \$150 Copay
OUTPATIENT SERVICES - When performed and billed in an outpatient facility		
Advanced imaging including:		
-- MRIs and MRAs	Deductible, then \$50	Deductible + 40%
-- CAT Scans	Deductible, then \$50	Deductible + 40%
-- PET Scans	Deductible, then \$50	Deductible + 40%
-- Nuclear Stress Tests	Deductible, then \$50	Deductible + 40%
Ambulatory Surgery - <i>only facility claim; physician and ancillary providers may bill separately and thus could result in additional member responsibility</i>	Deductible	Deductible + 40%
Chemotherapy and Radiation Services	Deductible	Deductible + 40%
Dialysis	Deductible	Deductible + 40%
Family Planning	Deductible	Deductible + 40%
Laboratory Services - <i>When specimen is drawn in an outpatient facility</i>	Deductible	Deductible + 40%
Radiology - <i>When test is performed in an outpatient facility</i>	Deductible, then \$50	Deductible + 40%
OTHER SERVICES		
Durable Medical Equipment (DME) - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Orthotics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Prosthetics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Home Health Care - <i>Limited to 60 visits annually</i>	Deductible	Deductible + 40%
Hospice	Deductible	Deductible + 40%
Skilled Nursing Facility - <i>Limited to 60 days annually</i>	Deductible	Deductible + 40%
Infertility Services - <i>Limited to \$1,500 annual benefit maximum</i>	No Cost to the member	Deductible + 40%
PRESCRIPTION DRUG COPAYMENTS AFTER DEDUCTIBLE		
Deductible	\$3,500	
Tier 1A - \$3 / Tier 1 - \$15 / Tier 2 - \$35 / Tier 3 - \$65 / Tier 4 - \$100	SEE PAGE 7 FOR MORE DETAILS	

\$5,000 PREMIER PLUS PLAN BENEFIT SUMMARY

BENEFITS	MEMBER PAYS	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	Individual: \$5,000 Family: \$15,000	Individual: \$5,000 Family: \$15,000
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: NA Family: NA	Individual: \$3,000 Family: \$9,000
PRIMARY CARE PHYSICIAN (PCP) SERVICES - When performed and billed in a physician's office.		
Office Visits	\$30 Copay	Deductible + 30%
Allergy Testing, Treatment and Injections	\$30 Copay	Deductible + 30%
Chemotherapy and Radiation	\$30 Copay	Deductible + 30%
Family Planning	\$30 Copay	Deductible + 30%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	\$30 Copay	Deductible + 30%
Radiology - <i>When test is performed in physician's office</i>	\$30 Copay	Deductible + 30%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
SPECIALIST PHYSICIAN SERVICES - When performed and billed in a physician's office.		
Office Visits	\$60 Copay	Deductible + 30%
Allergy Testing, Treatment and Injections	\$60 Copay	Deductible + 30%
Chemotherapy and Radiation	\$60 Copay	Deductible + 30%
Family Planning	\$60 Copay	Deductible + 30%
Laboratory Services - <i>When specimen is drawn in physician's office</i>	\$60 Copay	Deductible + 30%
Radiology - <i>When test is performed in physician's office</i>	\$60 Copay	Deductible + 30%
<i>Physician services are limited to one Copay per Member, per provider, per date of service and per place of service. Copay applies to every visit to the office.</i>		
PREVENTIVE HEALTH SERVICES		
Annual Adult Physical	No cost to the member	Deductible + 30%
Annual Well-Woman exam (<i>including annual Pap smear</i>)	No cost to the member	Deductible + 30%
Immunizations and Vaccines	No cost to the member	Deductible + 30%
Well-Child Care / Newborn Care	No cost to the member	30% Coinsurance
Mammogram	No cost to the member	Deductible + 30%
<i>This is not intended to be an all-inclusive list. Preventive Health Services are defined in the Patient Protection & Affordability Care Act and do not have any member cost sharing responsibility for In-Network services.</i>		
INPATIENT HOSPITAL SERVICES		
Inpatient Hospital Services	Deductible	Deductible + 30%
Inpatient Rehabilitation Facility	Deductible	Deductible + 30%
Physician Services	Deductible	Deductible + 30%
MATERNITY SERVICES		
Physician Services - <i>one time copay per pregnancy (In-Network Only)</i>	One time \$60 copay	Deductible + 30%
Inpatient Maternity Care	Deductible	Deductible + 30%
<i>Radiology (ultrasound) for Maternity, when done outside physician office may result in additional member responsibility.</i>		
OUTPATIENT THERAPY SERVICES		
Cardiac Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	\$60 Copay	Deductible + 30%
Pulmonary Rehabilitation Therapy - <i>Limited to 30 visits annually</i>	\$60 Copay	Deductible + 30%
Physical and Occupational Therapies - <i>Limited to 20 visits annually (combined)</i>	\$60 Copay	Deductible + 30%
Speech Therapy - <i>Limited to 20 visits annually</i>	\$60 Copay	Deductible + 30%
CONVENIENCE CARE SERVICES		
Convenience Care Visit	\$30 copay	\$30 copay
URGENT AND EMERGENT CARE		
Urgent Care in an Urgent Care Facility	\$75 Copay	\$75 Copay
Emergency Services - <i>Copay is waived if admitted</i>	\$200 Copay	\$200 Copay
Ambulance	\$200 Copay	\$200 Copay
OUTPATIENT SERVICES - When performed and billed in an outpatient facility		
Advanced imaging including:		
-- MRIs and MRAs	\$100 Copay + Deductible	Deductible + 30%
-- CAT Scans	\$100 Copay + Deductible	Deductible + 30%
-- PET Scans	\$100 Copay + Deductible	Deductible + 30%
-- Nuclear Stress Tests	\$100 Copay + Deductible	Deductible + 30%
Ambulatory Surgery - <i>only facility claim; physician and ancillary providers may bill separately and thus could result in additional member responsibility</i>	\$100 Copay + Deductible	Deductible + 30%
Chemotherapy and Radiation Services	Deductible	Deductible + 30%
Dialysis	Deductible	Deductible + 30%
Family Planning	Deductible	Deductible + 30%
Laboratory Services - <i>When specimen is drawn in an outpatient facility</i>	Deductible	Deductible + 30%
Radiology - <i>When test is performed in an outpatient facility</i>	Deductible	Deductible + 30%
OTHER SERVICES		
Durable Medical Equipment (DME) - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Orthotics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Prosthetics - <i>Coinsurance does not apply to Out-of-Pocket Maximum</i>	50%	50%
Home Health Care - <i>Limited to 60 visits annually</i>	Deductible	Deductible + 30%
Hospice	Deductible	Deductible + 30%
Skilled Nursing Facility - <i>Limited to 60 days annually</i>	Deductible	Deductible + 30%
Infertility Services - <i>Limited to \$1,500 annual benefit maximum</i>	No Cost to the member	Deductible + 30%
PRESCRIPTION DRUG COPAYMENTS		
Tier 1A - \$3 / Tier 1 - \$15 / Tier 2 - \$35 / Tier 3 - \$65 / Tier 4 - 10 % Coinsurance	SEE PAGE 7 FOR MORE DETAILS	

PREScription DRUG RIDER

\$3,500 CHOICE PLAN

PLAN DEDUCTIBLE REQUIREMENTS: You must pay the Plan Deductible each Benefit Year before You may receive Coverage for:

- Tier 2 Prescription Drugs
- Tier 3 Prescription Drugs
- Tier 4 Prescription Drugs

COPAYMENTS: Before copayments for Tiers 2, 3, and 4 apply you must pay the Medical Plan Deductible, the Your Copayment for up to a 31 day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- \$3 for Tier 1A Prescription Drugs - Deductible requirements do not apply
- \$15 for Tier 1 Prescription Drugs - Deductible requirements do not apply
- \$35 for Tier 2 Prescription Drugs
- \$65 for Tier 3 Prescription Drugs

After You have satisfied Your Health Plan Deductible as noted above, Your Copayment for Self-Administered Injectable Drugs and Specialty Pharmacy Drugs is:

- \$100 Copay

Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order copayment for a 93 day supply. After you have satisfied Your Health Plan Deductible as noted above, Your Mail Order Copayment for a ninety-three (93) day supply of Prescription Drugs is:

- 2x the copayment for Tier 1 or Tier 1A Prescription Drugs
- 2.5x the copayment for Tier 2 Prescription Drugs
- 3x the copayment for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Prescription Drugs and Specialty Medications

\$5,000 PREMIER PLUS PLAN

COPAYMENTS: Your Copayment for up to a thirty-one (31) day supply of Prescription Drugs *other than* Self-Administered Injectable Drugs is:

- \$3 for Tier 1A Prescription Drugs
- \$15 for Tier 1 Prescription Drugs
- \$35 for Tier 2 Prescription Drugs
- \$65 for Tier 3 Prescription Drugs

Your Coinsurance for Self-Administered Injectable or Specialty Pharmacy Tier 4 Prescription Drugs is:

- 10% Coinsurance, up to a \$2,500 Annual Out-of-Pocket Rider maximum

Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a 93 day supply. Your Mail Order Copayment for a ninety-three (93) day supply of Prescription Drugs is:

- 2x the copayment for Tier 1 or Tier 1A Prescription Drugs
- 2.5x the copayment for Tier 2 Prescription Drugs
- 3x the copayment for Tier 3 Prescription Drugs
- Mail order is not available for Tier 4 Prescription Drugs or Specialty Medications

ADDITIONAL PRESCRIPTION DRUG BENEFIT INFORMATION FOR BOTH PLANS

- The mail order Prescription Drug benefit is available through a mail order pharmacy designated by the Health Plan and/or certain Participating retail pharmacies. Prescription Drugs on the Mail Order Drug List may be dispensed with the applicable Mail Order Copayment for a ninety-three (93) day supply. Please note that not all Participating pharmacies provide this benefit. Please call Customer Service at 1-800-395-2545 for information on mail order pharmacies.
- Specialty Medications will only be available through Specialty Providers designated by the Health Plan.
- If a Tier 2 Prescription Drug is dispensed, and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available, You must pay the Tier 3 Prescription Drug Copayment.
- If a Tier 3 Prescription Drug is dispensed and a Therapeutically Equivalent Tier 1 or Tier 1A Prescription Drug is available You must pay the Tier 3 Prescription Drug Copayment.
- Coverage is subject to drug utilization guidelines including quantity limits and/or prior authorization. If a drug requires prior authorization or exceeds a specific quantity limit, the prescribing provider must contact the health plan *before* a prescription is filled or refilled.
- Payment for covered Prescription Drugs is limited to the contracted amount the Health Plan would normally pay, less the Member's applicable Copayment and/or Deductible.
- Payments you make for covered benefits under this rider do not count toward the deductible or out-of-pocket maximum under the health plan.
- You have the right to appeal any decision made by the health plan. You may obtain information on how to file an appeal by visiting our website at www.chcga.com or calling customer service at 1-800-395-2545.

This Vision Care Rider is an attachment to the Coventry Health Care of Georgia, Inc. ("Health Plan") Certificate of Coverage.

The Health Plan has contracted with specific Vision Network Providers for the provision of the routine vision care services covered under this Rider. **You must receive the services covered under this Rider from a Vision Network Provider. Vision care services provided by non-Vision Network Providers and Non-Participating Providers and not covered.** The Health Plan's current Vision Network Provider is Avesis, Inc.

Members Must Use an Avesis Vision Network Provider for Routine Vision Exams.

To obtain a list of Avesis Vision Network Providers:

Please visit our website at www.chcga.com
or call Customer Service at 1-800-395-2545

SECTION 1 - COVERED SERVICES

Subject to the limitations, exclusions Copayments and terms described herein, the following vision care benefits will be provided:

- A. Eye Examination.** An eye examination and refraction provided by a Vision Network Provider is covered under this Rider. Eye examinations include, at the Vision Network Provider's discretion and if Medically Necessary:
- B. Eyeglasses and Contact Lenses Benefits.** You are allowed a monetary allowance to be used toward the costs of standard eyeglasses and/or contact lenses as noted in the following chart. The Vision Network Provider shall apply this allowance toward the costs of eyeglasses (including lenses, frames or installation of lenses) or contact lenses (including lenses, fitting and follow-up care). You are responsible to pay for any costs relating to this benefit in excess of such allowance.
- (a) medical history
 - (b) evaluation of visual acuity
 - (c) external examination of the eye
 - (d) binocular measure
 - (e) ophthalmoscopic examination
 - (f) medication for dilating pupils and desensitizing the eyes for tonometry
 - (g) summary and findings
 - (h) a determination as to the need for correction of visual acuity
 - (i) prescribing lenses if needed
 - (j) confirming the appropriateness of eyeglasses or contact lenses obtained under the prescription

Benefits Covered	Member Pays	Frequency of Benefit
Eye Examination	\$15	1 exam every 12 months
Eyeglasses and/or Contact Lenses	You receive a \$100 Hardware Allowance at the time of purchase (Vision Network Provider subtracts \$100 from Your total hardware bill)	\$100 allowance every 12 months

SECTION 2 - LIMITATIONS AND EXCLUSIONS

- A. Limitations.** The benefits under this Rider may not be combined with any sale, special offer or promotional pricing. Payments you make for covered services under this Rider will not be applied to the Deductible or Out-of-Pocket Maximum under you health plan.
- B. Exclusions.** The following are not covered under this Rider:
- (a) Materials required by an employer as a condition of employment;
 - (b) Materials provided as a result of any workers compensation law or similar legislation;
 - (c) Any material obtained through, or required by, a governmental agency;
 - (d) Drugs or other medications not administered for the purpose of the vision examination;
 - (e) Special or unusual procedures, such as but not limited to, orthoptics, vision training, subnormal vision aids, rehabilitative services, tonography, or services which are experimental in nature;
 - (f) Cosmetic eye surgery, which includes any surgery for the improvement of appearance rather than the correction of vision; and
 - (g) Services provided by Non-Vision Network Providers and Non-Participating Providers, except in an emergency, as determined solely by the Health Plan.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)



Our Health Reimbursement Arrangement (HRA) administrator is MedCom out of Jacksonville, Florida. Each employee enrolled in a medical plan will automatically be enrolled in our HRA. Money in the account will only be allowed for the following reimbursements:

\$3,500 Choice Plan - The HRA will reimburse the last \$1,000 of the calendar year deductible.

\$5,000 Premier Plus Plan - The HRA will reimburse the last \$2,500 of the calendar year deductible

HOW DOES THE HRA WORK?

The calendar year deductible for the Choice Plan is \$3,500 and \$5,000 on the Premier Plus Plan. To assist employees who meet this deductible, the City is funding a Health Reimbursement Arrangement (HRA) that will reimburse each person the last portion of their deductible (\$1,000 for the Choice Plan and \$2,500 on the Premier Plus Plan) IF you have a claim. This means your *NET DEDUCTIBLE* will be \$2,500 per year on either plan.

If you cover family members on your medical plan the HRA will reimburse the last portion of their deductibles as well.

WHAT EXPENSES ARE COVERED UNDER AN HRA?

- City of Locust Grove will reimburse the last **\$1,000 of your** insurance deductible on the **\$3,500 Choice Plan** and **\$2,500** on the **\$5,000 Premier Plus Plan** (this makes your net deductible \$2,500 on both plans).

HOW ARE EXPENSES REIMBURSED?

In order to receive payment, you must send a completed Reimbursement Form and Explanation of Benefits (EOB) to MedCom in one of the following ways:

- A completed Reimbursement Form and EOB can be mailed to:
MedCom Flex Dept
P.O. Box 10269
Jacksonville, FL 32247-0269
Telephone: 800-523-7542 Option 1
- A claim may be filed via e-mail and sent to MedcomReceipts@medcom.net, you can scan the Reimbursement Form and EOB.
- You can fax the Reimbursement Form and EOB to:
Fax: 877-723-0149
- You can submit online at www.mywealthcareonline.com/medcom

Once the claim has been processed a check will be issued and mailed directly to the participant.

WHAT IS AN EOB?

An Explanation of Benefits (EOB) is a form or document that is sent to you by Coventry after you had a healthcare service that was paid by the insurance company. Your EOB gives you information about how an insurance claim from a health provider (such as a doctor or hospital) was paid on your behalf. An EOB has the following information: Name of patient who received service, Claim Number, Provider, Type of Service, Date of Service, the amount of payment actually made to your provider and how much of your annual deductible has been met. The EOB is required in order for you to receive reimbursement from the HRA.

WHERE DO I FIND A REIMBURSEMENT FORM?

There is a reimbursement form included in your open enrollment packet. You may request additional forms from MSI Benefits Group, Inc. by calling 800-580-1629, by visiting http://www.medcom.net/forms/CLAIM_FORM.pdf or by visiting your Human Resources Department.

ONLINE ACCOUNT ACCESS

Active participants may track their HRA account status online. Simply log onto www.medcom.net, and click on "Employee Login" to create your account.

RUNOUT PERIOD (TIMELY FILING)

All claim forms must be submitted, in order to be considered for reimbursement for 2018 services, by March 31, 2019. If a claim form is submitted after this deadline it will be denied due to timely filing.

DENTAL BENEFIT SUMMARY

Coverage Type	In-Network % of PDP Fee	Out-of-Network % of R&C Fee ¹
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible	In-Network	Out-of-Network
Individual	\$50 Applies to Type B & C services only	\$50 Applies to Type B & C services only
Family	\$150 Applies to Type B & C services only	\$150 Applies to Type B & C services only
Annual Maximum Benefits	In-Network	Out-of-Network
Per Individual	\$1,500	\$1,500
Orthodontia Lifetime Maximum Per Individual	\$1,500	\$1,500
	Ortho applies to Adult and Child (Up to age 26)	
Dependent Age:	Eligible for benefits until the day that he or she turns 26.	

1. The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90th Percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

Understanding Your Dental Plans

The MetLife Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice – in or out of the network.

If you receive in-network services, you will be responsible for any applicable cost sharing, PDP charges in excess of the benefit maximums, and for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the PDP fee schedule amount, and charges for non-covered services.

Plan benefits for in-network services are based on the percentage of the PDP fee – MetLife's negotiated fees that PDP dentists have agreed to accept as payment in full.

Plan benefits for out-of-network services are based on the percentage of the Reasonable and Customary (R&C) charges. If you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, go to www.metlife.com/mybenefits and follow the easy registration instructions.

The City of Locust Grove pays 100% of the cost for this benefit.

DENTAL BENEFIT SUMMARY



Type A - Preventive	How Many / How Often
<ul style="list-style-type: none"> • Prophylaxis – Cleanings • Oral Examinations • Topical Fluoride Applications • Full Mouth X-Rays • Bitewing X-Rays (Adult/Child) • Space Maintainers • Sealants 	<ul style="list-style-type: none"> 1 in 6 months 1 in 6 months 2 in 12 months for children up to 14th birthday. 1 in 60 months 1 in 12 months - Child to 19th birthday Children up to 14th birthday. Limited to 1 per lifetime per area. 1 per molar in 60 months children up to 14th birthday.
Type B - Basic Restorative	How Many / How Often
<ul style="list-style-type: none"> • Space Maintainers • General Anesthesia • Oral Surgery (Simple Extractions) • Oral Surgery (Surgical Extractions) • Other Oral Surgery • Amalgam & Resin Composite Fillings • Periodontal Maintenance • Periodontal Surgery • Root Canal • Scaling and Root Planing 	<ul style="list-style-type: none"> 1 per tooth in 24 months For oral surgery, extractions or other covered services 1 per tooth surface in 24 months, Composite fillings included for molars 4 perio treatments in 1 calendar year, includes 2 cleanings 1 per quadrant in any 36 month period 1 per tooth per lifetime 1 per quadrant in any 24 month period
Type C - Major Restorative	How Many / How Often
<ul style="list-style-type: none"> • Consultations • Prefabricated Crowns • Repairs • Dentures • Fixed Bridges • Inlays / Onlays / Crowns • Implant Services • Tissue Conditioning • Occlusal Adjustments 	<ul style="list-style-type: none"> 2 in 12 months 1 per tooth in 10 calendar years 1 in 24 months 1 in 10 calendar years 1 in 10 calendar years 1 replacement per tooth in 10 calendar years 1 per tooth position in 10 calendar years 1 in 36 months 1 in 12 months
Type D Orthodontic Services	
<ul style="list-style-type: none"> • Orthodontic Diagnostics • Orthodontic Treatment 	

BASIC TERM LIFE and AD&D INSURANCE

The death of a family provider can mean that a family will not only find itself facing the loss of a loved one, but also the loss of financial security. With our Group Term Life Plan, employees can achieve peace of mind by giving their family the security they can depend upon.



ELIGIBILITY

Coverage for all full-time employees.

BENEFIT AMOUNT

Basic Group Term Life Insurance is equal to **\$50,000**

AGE REDUCTION

Benefits are reduced to 65% at age 65 and 50% at age 70. Coverage is discontinued at termination of employment or retirement.

ACCIDENTAL DEATH and DISMEMBERMENT (AD&D)

AD&D insurance which could pay an additional benefit, up to the amount of your Life benefit, if you suffer a covered loss due to an accident

ACCELERATED BENEFITS

Accelerated benefits help offset expenses at a critical time. You may collect a portion of your benefits during your lifetime if you become terminally ill.

PORTABILITY

When coverage ends for reasons other than sickness, injury, retirement, or termination of the employer's plan, employees can apply for a portable Term Life policy without Evidence of Insurability.

Actively at Work

Your life insurance policy will terminate if you have not been **ACTIVELY AT WORK** within the last **12 months**. To continue coverage you must elect a portability or conversion option within 31 days of your coverage terminating.

POLICHOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

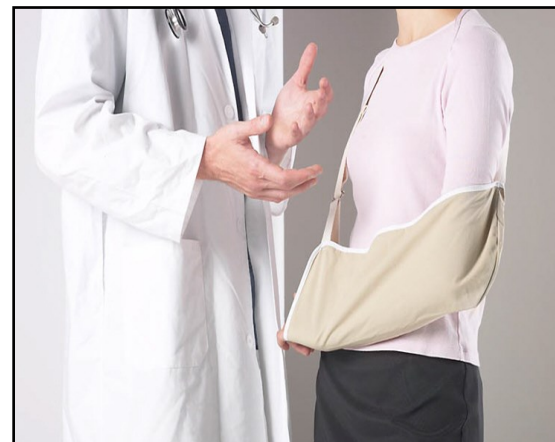
Basic group term life coverage begins automatically when you meet the eligibility requirements. You'll need to designate beneficiaries for your basic life benefits using a group enrollment form.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Dearborn National booklet containing complete plan details will be available in the Human Resources Department.

Short Term Disability (STD) helps protect the financial health of you and your family should you ever suffer a disability that prevents you from working for months or even years. We focus on returning disabled employees to productive work whenever possible.

This page highlights the benefits available through your employer. For more information see the Dearborn National STD booklet available from your employer.



ELIGIBILITY

Coverage for all full-time employees working 30 or more hours per week.

STD BENEFIT AMOUNT

60% of your weekly salary up to a maximum of \$1,000 per week for covered accident and sickness.

ELIMINATION PERIOD

Benefits begin on the **8th day** absent for covered accidents and on the **8th day** for covered sickness.

MAXIMUM BENEFIT DURATION

25 Weeks

POLICOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

Short Term Disability coverage begins automatically when you meet the eligibility requirements and satisfy the waiting period.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Dearborn National booklet containing complete plan details will be available in the Human Resources Department.

GROUP LONG TERM DISABILITY

Long Term Disability (LTD) helps protect the financial health of you and your family should you ever suffer a disability that prevents you from working for months or even years. We focus on returning disabled employees to productive work whenever possible.

This page highlights the benefits available through your employer. For more information see the Dearborn National LTD booklet available from your employer.



ELIGIBILITY

Coverage for all full-time employees working 30 or more hours per week.

LTD BENEFIT AMOUNT

60% of your monthly pay up to a maximum of \$4,000 per month for covered accident and sickness.

ELIMINATION PERIOD

Benefits begin after you have been absent from work for **180 days** of absences due to a covered accident or sickness.

MAXIMUM BENEFIT DURATION

Social Security Normal Retirement Age (SSNRA)

POLICOLDER CONTRIBUTION

The City of Locust Grove pays 100% of the cost for this coverage.

HOW TO ENROLL

Long Term Disability coverage begins automatically when you meet the eligibility requirements.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Dearborn National booklet containing complete plan details will be available in the Human Resources Department.

VOLUNTARY TERM LIFE and AD&D INSURANCE

BENEFIT AMOUNT

For you: An amount between \$10,000 and \$300,000, in increments of \$10,000, not to exceed 5x basic annual earnings. Benefits cease at retirement.

For your spouse: An amount between \$5,000 and \$150,000 in increments of \$5,000. Spouse voluntary life coverage may not exceed 50% of the employee's coverage. Coverage ends when your spouse turns 70.

For your dependent child(ren): \$10,000. Child voluntary life coverage may not exceed 50% of the employee's coverage. Eligible children include unmarried children from 14 days to age 19 or to age 24 if a full-time student.

You must elect voluntary life insurance on yourself in order to cover your spouse and/or children.



AGE REDUCTION

Employee: All coverage amounts reduce to 65% at age 65, 50% at age 70.

Spouse: None

Child(ren): None

GUARANTEED ISSUE (GI) AMOUNTS

GI is the amount of life insurance available to you without Evidence of Insurability (medical questions). GI is only available during your initial eligibility period.

Employee: \$100,000

Spouse: \$ 25,000

Child: \$ 10,000

ACCIDENTAL DEATH and DISMEMBERMENT (AD&D)

Protection for covered Accidental Death and covered injuries such as speech/hearing, loss of limb, loss of use of a limb due to quadriplegia, paraplegia, or hemiplegia, and thumb and index finger. AD&D cost is included in the rates on the following page.

WAIVER OF PREMIUM

Waiver benefits protect employees who are totally disabled, as defined by the policy.

PORTABILITY

When coverage ends for reasons other than sickness, injury, retirement, or termination of the employer's plan, employees can apply for a portable Term Life policy without Evidence of Insurability.

FOR COMPLETE PLAN DETAILS

This highlight flyer is intended to provide an overview of the benefits available from the City of Locust Grove and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under this plan. The Dearborn National booklet containing complete plan details will be available in the Human Resources Department.

VOLUNTARY TERM LIFE and AD&D INSURANCE

EMPLOYEE VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS

AGE	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	\$0.46	\$0.51	\$0.55	\$0.60	\$0.92	\$1.38	\$2.35	\$3.92	\$5.40	\$9.41	\$19.33	\$29.58
\$20,000	\$0.92	\$1.02	\$1.11	\$1.21	\$1.85	\$2.77	\$4.71	\$7.85	\$10.81	\$18.82	\$38.67	\$59.17
\$30,000	\$1.38	\$1.54	\$1.66	\$1.81	\$2.77	\$4.15	\$7.06	\$11.77	\$16.21	\$28.23	\$58.00	\$88.75
\$40,000	\$1.85	\$2.05	\$2.22	\$2.42	\$3.69	\$5.54	\$9.42	\$15.69	\$21.62	\$37.64	\$77.34	\$118.34
\$50,000	\$2.31	\$2.56	\$2.77	\$3.02	\$4.62	\$6.92	\$11.77	\$19.62	\$27.02	\$47.05	\$96.67	\$147.92
\$60,000	\$2.77	\$3.07	\$3.32	\$3.63	\$5.54	\$8.31	\$14.12	\$23.54	\$32.43	\$56.46	\$116.00	\$177.51
\$70,000	\$3.23	\$3.59	\$3.88	\$4.23	\$6.46	\$9.69	\$16.48	\$27.46	\$37.83	\$65.88	\$135.34	\$207.09
\$80,000	\$3.69	\$4.10	\$4.43	\$4.84	\$7.38	\$11.08	\$18.83	\$31.38	\$43.24	\$75.29	\$154.67	\$236.68
\$90,000	\$4.15	\$4.61	\$4.98	\$5.44	\$8.31	\$12.46	\$21.18	\$35.31	\$48.64	\$84.70	\$174.00	\$266.26
\$100,000	\$4.62	\$5.12	\$5.54	\$6.05	\$9.23	\$13.85	\$23.54	\$39.23	\$54.05	\$94.11	\$193.34	\$295.85
\$110,000	\$5.08	\$5.64	\$6.09	\$6.65	\$10.15	\$15.23	\$25.89	\$43.15	\$59.45	\$103.52	\$212.67	\$325.43
\$120,000	\$5.54	\$6.15	\$6.65	\$7.26	\$11.08	\$16.62	\$28.25	\$47.08	\$64.86	\$112.93	\$232.01	\$355.02
\$130,000	\$6.00	\$6.66	\$7.20	\$7.86	\$12.00	\$18.00	\$30.60	\$51.00	\$70.26	\$122.34	\$251.34	\$384.60
\$140,000	\$6.46	\$7.17	\$7.75	\$8.46	\$12.92	\$19.38	\$32.95	\$54.92	\$75.66	\$131.75	\$270.67	\$414.18
\$150,000	\$6.92	\$7.68	\$8.31	\$9.07	\$13.85	\$20.77	\$35.31	\$58.85	\$81.07	\$141.16	\$290.01	\$443.77
\$200,000	\$9.23	\$10.25	\$11.08	\$12.09	\$18.46	\$27.69	\$47.08	\$78.46	\$108.09	\$188.22	\$386.68	\$591.69
\$250,000	\$11.54	\$12.81	\$13.85	\$15.12	\$23.08	\$34.62	\$58.85	\$98.08	\$135.12	\$235.27	\$483.35	\$739.62
\$300,000	\$13.85	\$15.37	\$16.62	\$18.14	\$27.69	\$41.54	\$70.62	\$117.69	\$162.14	\$282.32	\$580.02	\$887.54

SPOUSE VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS (BASED ON EMPLOYEE AGE)

AGE	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$5,000	\$0.23	\$0.26	\$0.28	\$0.30	\$0.46	\$0.69	\$1.18	\$1.96	\$2.70	\$4.71
\$10,000	\$0.46	\$0.51	\$0.55	\$0.60	\$0.92	\$1.38	\$2.35	\$3.92	\$5.40	\$9.41
\$15,000	\$0.69	\$0.77	\$0.83	\$0.91	\$1.38	\$2.08	\$3.53	\$5.88	\$8.11	\$14.12
\$20,000	\$0.92	\$1.02	\$1.11	\$1.21	\$1.85	\$2.77	\$4.71	\$7.85	\$10.81	\$18.82
\$25,000	\$1.15	\$1.28	\$1.38	\$1.51	\$2.31	\$3.46	\$5.88	\$9.81	\$13.51	\$23.53
\$30,000	\$1.38	\$1.54	\$1.66	\$1.81	\$2.77	\$4.15	\$7.06	\$11.77	\$16.21	\$28.23
\$35,000	\$1.62	\$1.79	\$1.94	\$2.12	\$3.23	\$4.85	\$8.24	\$13.73	\$18.92	\$32.94
\$40,000	\$1.85	\$2.05	\$2.22	\$2.42	\$3.69	\$5.54	\$9.42	\$15.69	\$21.62	\$37.64
\$45,000	\$2.08	\$2.31	\$2.49	\$2.72	\$4.15	\$6.23	\$10.59	\$17.65	\$24.32	\$42.35
\$50,000	\$2.31	\$2.56	\$2.77	\$3.02	\$4.62	\$6.92	\$11.77	\$19.62	\$27.02	\$47.05
\$55,000	\$2.54	\$2.82	\$3.05	\$3.33	\$5.08	\$7.62	\$12.95	\$21.58	\$29.73	\$51.76
\$60,000	\$2.77	\$3.07	\$3.32	\$3.63	\$5.54	\$8.31	\$14.12	\$23.54	\$32.43	\$56.46
\$65,000	\$3.00	\$3.33	\$3.60	\$3.93	\$6.00	\$9.00	\$15.30	\$25.50	\$35.13	\$61.17
\$70,000	\$3.23	\$3.59	\$3.88	\$4.23	\$6.46	\$9.69	\$16.48	\$27.46	\$37.83	\$65.88
\$75,000	\$3.46	\$3.84	\$4.15	\$4.53	\$6.92	\$10.38	\$17.65	\$29.42	\$40.53	\$70.58
\$100,000	\$4.62	\$5.12	\$5.54	\$6.05	\$9.23	\$13.85	\$23.54	\$39.23	\$54.05	\$94.11
\$125,000	\$5.77	\$6.40	\$6.92	\$7.56	\$11.54	\$17.31	\$29.42	\$49.04	\$67.56	\$117.63
\$150,000	\$6.92	\$7.68	\$8.31	\$9.07	\$13.85	\$20.77	\$35.31	\$58.85	\$81.07	\$141.16

DEPENDENT CHILD(REN) VOLUNTARY TERM LIFE and AD&D INSURANCE - BI-WEEKLY DEDUCTIONS

\$10,000 Life and AD&D Insurance \$1.06

Employee Assistance Program

Service Summary

City of Locust Grove

Anthem®EAP

The Anthem Employee Assistance Program (EAP) provides solutions to help you balance work and life through confidential and easily accessible services. Anthem EAP puts convenient resources within your reach, and that helps you – and your household members – stay healthy. Your Anthem EAP services will include:

Face-to-Face Counseling. You and your household members are eligible for up to 4 visits for each personal situation, as needed. You don't have to have Anthem insurance to qualify for this benefit. You can simply call the toll-free Anthem EAP number or access services online using the "Member Center."

Legal Assistance. You can receive a free 30 minute consultation in person or over the phone at a time that is convenient for you. You can even receive a discount on fees should you retain the attorney. Online resources include free legal forms, seminars and a full library of articles.

Financial Assistance. Our financial professionals provide free telephonic consultation on the financial topics that are important to you. Counseling sessions have no time limitations, and are available without appointment during regular business. Online resources include an assortment of financial calculators and access to PocketSmith, a budgeting and management tool.

ID Recovery. Specialists are available 24/7 to assess your risk level and then identify steps to resolve potential identity theft. All services are provided to you free of charge. This may include completing any necessary paperwork, reporting to the consumer credit agencies, and negotiating with creditors to repair debt history. Our specialists will work with you to restore your financial identity to its pre-theft status.

Tobacco Cessation (Online and Coaching)

Online Program: LivingFree™ is a free 10 sessions, online training program which will help you learn how to break the tobacco habit. The program focuses on the root emotional and physical causes of using tobacco.

Telephonic Coaching: A free service provided via telephone or through instant messaging. The certified Coach will help you address the triggers of your tobacco use and how to overcome them as well as address issues related to weight management and fitness.

Dependent Care and Daily Living Resources. You and your household members can get information on child care, adoption, summer camps, college placement relocation, plus resources on elder care issues and assisted living by accessing the website or calling your EAP toll-free number.

Other Web Resources. Full library of health and emotional well-being articles. Monthly webinars. Self-assessment tools on topics such as depression, relationships, anxiety, anger, alcohol, eating and more.

Crisis Consultation. If you have an emergency, simply call the Anthem toll-free number. Consultants are available 24/7/365 to help or just listen, depending on your needs.

To contact Anthem EAP, please call us toll-free at 1-800-865-1044 or visit us at www.anthemead.com.

Enter your company code: City of Locust Grove

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Confidentiality: No one will know you've called EAP unless you give them permission in writing in accordance with federal and state law, and professional ethical standards. For program limitations and exclusions contact your EAPs toll-free number.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

CITY of LOCUST GROVE HEALTH PLAN

Introduction

You are receiving this notice because you have recently become eligible for the City of Locust Grove health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice **in writing** to: **Human Resources, City of Locust Grove, P.O. Box 900, Locust Grove, GA 30248.**

CONTINUATION COVERAGE RIGHTS UNDER COBRA

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request from:

**Human Resources
City of Locust Grove
P.O. Box 900
Locust Grove, GA 30248
Phone: 770-957-5043**

NOTES

IMPORTANT CONTACT INFORMATION

City of Locust Grove

Misty Titshaw

City Clerk

Tel: 770-957-5043

Mtitshaw@locustgrove-ga.gov

Tracey Sullivan

Human Resources Specialist

Tel: 770-957-5043

TSullivan@locustgrove-ga.gov

MEDICAL PLANS

Coventry Health Care of Georgia

Customer Service

Tel: 800-395-2545

Behavioral Health and Substance

Abuse Services

Tel: 800-752-7242

Pharmacy Help Desk

Tel: 800-378-7040

www.chcga.com

MSI BENEFITS GROUP, INC.

Administrative Contact

Tel: 770-425-1231 / 800-580-1629

Fax: 770-425-6275 / 800-580-2675

Email: HelpMe@msibg.com

Online: www.msibenefitsgroup.com

DENTAL PLAN

MetLife

Customer Service

Tel: 800-942-0854

www.metlife.com

LIFE / DISABILITY INSURANCE

Dearborn National

Life: 800-348-4512

www.dearbornnational.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Anthem

Tel : 800-865-1044

www.anthemap.com

Company Code: City of Locust Grove

This booklet is a summary only. Please refer to each plan's certificate of coverage / plan document for a complete description of all benefits and exclusions. If there is any difference between the information provided in this booklet and any certificate of coverage / plan document, the certificate of coverage / plan document will govern. Copies of all certificates of coverage / plan documents are available in the Human Resources department. In the event that some information changes, you will receive notice about the changes prior to the annual Open Enrollment. If you are a new employee, this information will help you to understand the benefit options available to you. If you're already covered by any of the benefit plans, you may refer to this booklet throughout the year as you use your benefits. This booklet also provides information regarding your COBRA rights and responsibilities.



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